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ABSTRACT

Described in the third of three reports from a staff training program at the University of Texas at Austin is a program for parent involvement in a short term center for learning disabled and emotionally disturbed preschoolers. It is explained that the program focuses on the parent's role as principle therapist for the child. Among program components reviewed are parent education groups (discussions covering such topics as behavior management), family demonstration therapies (observation sessions by parents), and parent counseling conferences (meetings to evaluate child progress and facilitate family communication). Analyzed are steps involved in helping parents assume a staff-partner role, and examined are potential obstacles to meaningful parent-staff interaction. (CL)

THE UNIVERSITY OF TEXAS AT AUSTIN

Program for Staff Training of Exemplary Early Childhood Centers

for Handicapped Children

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P R E S E N T S

THE STAFF TRAINING PROTOTYPE SERIES

PARENTS AS STAFF PARTNERS

(A Program for Parent Involvement
in a Short Term
Preschool Psychiatric Center)

by

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Vol.III No.1

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I. INTRODUCTION

In recognition of the abundant evidence that the preschool years are the most critical for future development, and that there were few programs for the handicapped child during this early "development-education" period, the President signed, on September 30, 1968, Public Law 90-538, the Handicapped Children's Early Education Assistance Act. The Act authorized the Commissioner of Education to make grants to or contracts with public agencies and private non-profit organizations to develop and operate preschool and early education model programs which show promise of promoting comprehensive and strengthened approaches to educational and other special problems of handicapped children. It was believed that these programs would demonstrate effective educational approaches which would represent a step forward in bringing about a meaningful development of the numerous preschool and early education programs so critically needed for handicapped children. Handicapped children were defined as those children, who, by reason of physical, emotional, or other health impairment, require special education and related services. Children who were considered handicapped by reason of environmental disadvantages or with problems of minor or short duration were not included.

Further, it was directed that model programs should demonstrate a high quality of services, should maintain visibility for both the general and professional communities, and should provide a structure so that others can replicate or adapt exemplary program components to meet their own needs.

A. PURPOSE:

Under the Act, one of the project requirements deals specifically with the participation in program activities by the parents of the handicapped children. The Policies and Procedures booklet issued by the Bureau of Education for the Handicapped, U. S. Office of Education, states: "There must be activities and services designed to encourage participation of the parents of the handicapped children served in the development and operation of any such project. Parents and other close family members can make vitally important contributions to programs for young handicapped children through a wide range of activities, depending on individual needs, resources, talents, and situations..."

In December of 1969, in a supplement to this booklet, the Bureau of Education for the Handicapped again re-emphasized the vital importance of parent participation by directing the model programs to provide: (1) opportunities for parents to share in program planning; (2) training to

parents and others who spend a considerable amount of time with the child; (3) opportunities for parents to offer their assessments of the program's effectiveness; and, (4) plans for active parent participation, including carry-over into home situations where appropriate.

The purpose of this paper is to present the background, the underlying rationale, the approaches, and some of the problems encountered in relation to Parent Participation in a short-term preschool psychiatric setting.

II. BACKGROUND

A. The Julia Ann Singer Preschool Psychiatric Center

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The Julia Ann Singer Preschool Psychiatric Center has been providing treatment for troubled young children and their families since 1961. The Center is affiliated with the Department of Child Psychiatry, Divisions of Psychiatry, Cedars-Sinai Medical Center,

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Los Angeles, California, and is under the direction of Frank S. Williams, M.D., Assistant Chief, Child Psychiatry.

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The majority of children accepted at the Center present primarily a variety of neurotic and behavioral pboblems, including

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psychosis and minimal neurological handicaps.

Most struggle with severe learning disabilities. The basic concept and purpose of

Slide #5 the Center is to provide the family and the community with the help necessary to enable the child to receive long-term educational treatment directly in the community, in as

Slide #6 normal a setting as possible. Each family and its potential regular community school become the focus of a 3-to-6-month therapeutic and educational program carefully designed for the particular problems presented. A major goal of our work aims at helping the parents to modify those familial factors which perpetuate the child's disturbance.

On July 1, 1969, a Planning Grant was awarded through the Bureau of Education for

Slide #7 the Handicapped to the Julia Ann Singer Preschool Psychiatric Center (JAS) for a project entitled, "A Comprehensive Educational-Consultative-Family Oriented Program for Seriously Emotionally Disturbed Preschool Children." Among the major objectives of this proposal were two which are germane to this paper:

(1) Maximizing the use of parents and teachers in normal school settings

as the primary therapeutic agents.

(2) Providing ongoing effective professional consultation from our staff to teachers in normal school settings, pediatricians, family doctors, and parents, in an effort to maintain the child within a normal school experience, following our Center's short-term evaluation and treatment intervention.

Prior to the awarding of the Planning Grant, the staff of JAS, in its close working affiliation with the Department of Child Psychiatry at Cedars-Sinai Medical Center in Los Angeles, had paid particular attention to the use of family demonstration techniques and parent education. It appeared to us that traditional child guidance approaches often underline within a parent a sense of being guilty--of being the "heavies" who have made their children disturbed. It had been our experience that advice-giving to parents, without concomitant demonstration, had not been effective and often resulted in a tendency on the part of the parents to become too dependent upon the child's psychotherapist and/or his teacher.

With the introduction of the use of family interviewing techniques, we discovered that many of our staff began to see better results with even our most severely disturbed autistic children. Partially as a result of our experimentation in family interviewing techniques, we began to be very impressed with the value of direct demonstration to parents of the degree of communications capacity--both receptive and expressive--available even to the very young preschool child. Accordingly, then, we began

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to modify and streamline these techniques so that the emphasis was upon the parent quickly taking over as therapist, receiving reassurance and constructive criticism from the staff therapist. In every case we began to count upon bringing out the parents' strengths through their active participation with their disturbed children.

Reserving psychodynamic interpretation only for those situations in which the parents

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were unable to identify with the teacher and/or the therapist's demonstration of approaches to the child, our first line of intervention was aimed at better equipping the parent to focus

on the child's needs, rather than to encourage too much self-preoccupation by the parent. As a result of these experiences, we decided that during the planning year of the grant we would explore the implementation of parents as volunteer aides in the classroom, as well as for home visits and for liaison work with normal community schools.

In addition to exploring new methods of parent involvement, the staff at JAS was strongly committed to discovering ways of expanding and enhancing the three main opportunities for parent participation which we then provided. These were:

(1) Parent Education Groups

(2) Family Demonstration Therapies

(3) Parent Counseling Conferences

Although these three modalities were originally instituted as treatment forms, they proved to be necessary steps toward our long-range goal of helping parents to achieve a position of staff-partnership. Therefore, a few words about each of these methods seems pertinent.

Slide #10 B. Parent Education Groups:

The over-all purpose of our Parent Education

Groups is to enable parents and interested others to gain a fuller understanding of the psycho-sexual development of children in order to have a frame of reference through which they could facilitate and stimulate the growth and development of children. Underlying this purpose was our desire to acquaint the larger community with an in-depth understanding of the problems, limitations and potentials of children in general, as well as of disturbed children. Since the major focus of these groups is on "education", emphasis on the therapeutic aspects of the group meetings is given secondary attention.

Sometimes didactic in nature, but usually in the form of animated group discussions, these meetings are supplemented by audio-visual aids, such as motion pictures, videotapes, and pamphlets on pertinent problems in child rearing which are made available to the parents on a loan basis.

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These group meetings soon began to point to the attainment of several of our goals:

(1) Consideration of adult perceptions of behavioral problems in children as

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these relate to the general tasks confronted by children in their psycho-sexual, social, and intellectual development.

(2) Helping adults understand and differentiate between behavior which is acceptable and predictable and that which is not--in other words, age-appropriateness--in order to aid the child in the achievement of his potentials for learning and social reciprocity within his constitutional and neuro-organic limitations.

(3) Exploring ways in which adults can encourage language growth and communications development in the child through elementary verbal stimuli.

(4) Helping parents and others discover and put into practice effective means of handling behavior of children, especially in helping them to change that which is unacceptable and inappropriate into that which is acceptable and appropriate, particularly in relation to functioning in school group settings.

(5) Enabling professional staff to identify those parents who need a more direct and intensive education in the parent-child relationship, as well as those who may need psychiatric help.

Parents have proven to be extremely keen about sharing experiences and helping each other; and this, combined with the more formal factual presentations, appears to benefit them greatly in their parenting roles. Many parents tend to lend an extra measure of help to newer members in the group.

It is significant to note that prior to our institution of these groups, the doors of

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our observation rooms had a forbidding sign which read, "AUTHORIZED PERSONNEL ONLY." Agency policy in those days was to keep parents out of the observation room, and if they HAD to be in there, they could only do so when accom-

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panied by one of our staff. Today, the signs are gone; parents move freely about the agency and are encouraged to observe as much as they

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can, not only concerning their own child, but others as well. While observing, parents are

encouraged to discuss the children with each other; to exchange helpful criticisms; to question staff and to offer suggestions. When the parents of a new child begin to observe, more experienced parents are urged to help

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these parents by making them knowledgeable in good observation techniques and in explaining classroom procedures insofar as they are able. In almost every case, these parents seem to develop a sense of unity and mutual self-help which seems to have a strong carry-over into their daily family lives.

We have noticed that for several of our parents, these opportunities for observations with other parents readily become social occasions. This, we feel, has positive and negative features; positive when it does not distract from the goals of observation; negative when it results in an observation room that resembles a neighborhood kaffee klatsch.

The purpose of observation is obvious. Parents can learn from these experiences which may also, in turn, provide valuable feedback from parents to staff. We are con-

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vinced that encouragement of parents to

feed back to the staff their suggestions, impressions, and criticisms is essential to the swift establishment of parental participation in the development and operation of the total program.

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C. Family Demonstration Therapies:

The Family Demonstration Therapies portion of our program offers to parents knowledge and techniques to alter behavioral problems in their children, as well as an opportunity to practice these skills in a controlled environment, under supervision of a staff member. During the no more than 12 weekly one-hour sessions, parents observe directly or via the one-way mirror a staff member interacting with their children. Often there are other observers, including staff, other parents, trainees, and so forth; the parents are soon made to feel part of this team which is expending its efforts and knowledge in helping them with their child. An interesting situation which may often occur is that it is usually the professionals who feel uncomfortable observing in the presence of the parents, rather than the other way round. However, these feelings soon dissipate themselves as parents

demonstrate over and over again their ability to benefit from the experience, by quickly employing similar methods geared to elicit more wholesome parent-child interactions and more appropriate social behavior and learning skills by the child.

Slide #19 or Proj. #2

The purpose of the family's therapist is to demonstrate that behavior is understandable and changeable within the child's limitations and potential, and that even the very young preschooler can communicate and can understand adult communication. The therapist enlists the parents as allies in an effort to discover and correct ways in which the parents unknowingly perpetuate inappropriate behavior and learning blocks in the child. He guides the parents toward a realistic perception of the child's potential and limitations intellectually, physically, and socially. He helps parents toward a realistic perception of the child's potential and limitations intellectually, physically and socially. He further helps parents understand how their own feelings regarding the child and the child's handicap may serve to block the child's maximum growth and development.

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Goals for each family are highly individualized. For example, in one instance, one of the goals may be to help the mother to have more confidence in the father's parenting abilities and to be less protective of the child. In another, or perhaps the same family, a possible goal might be to help the father see his child more realistically, especially in regard to his expectations as a parent. Often the goal is to help either or both parents to relate to the child on a more appropriate level. Goals for the child can include helping him with more appropriate expressions of his feelings; invading his controlling behavior while still allowing him age-appropriate autonomy; and helping him in the area of social reciprocity within the context of the family situation. Again, feedback from parents experiencing Family Demonstration Therapy is strongly encouraged.

Slide #21 D. Parent Counseling:

Most Parent Counseling conferences at JAS take place on a regularly scheduled basis; however, they are also held at the request of either the parent or the eudcational therapist

Slide #22 assigned to the child. These conferences

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or
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serve several purposes: (1) They are a vehicle for a periodic exchange of views regarding the child's initial adjustment, the meaning and handling of certain behaviors and an evaluation of the child's progress. (2) Many parents feel that they cannot reach their child whom they see as incapable of understanding spoken language. They do not make demands for fear of provoking temper tantrums in the child, or stirring up great frustrations within themselves. In these instances, the parent, the educational therapist, and the child may meet jointly in order to discuss and demonstrate alternate approaches and methods of setting limits. Realistic expectations are explored and parents are encouraged to try the techniques. This approach is very valuable in averting over-dependency upon the teacher and helps to bring out the parent's strengths, reaffirming the agency message to parents that they are people of capabilities in regard to their children, and that we, the "professionals," know that they can adequately perform their parenting role.

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(3) Often parents experience great difficulty communicating to their children

around highly emotionally charged crises such as death, divorce, separation, a serious illness, a new sibling, the child's approaching hospitalization, and so forth. In these cases, parent, teacher and child discuss the situation openly, together. The child has an opportunity to voice his feelings and to ask questions about the existing tensions. Communication among family members is facilitated, as parents learn to identify with the teacher's timing and empathic responses geared to meet the child's level of understanding and emotional readiness.

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Furthermore, these conferences can contribute a great deal to the teacher's understanding about the correct timing to begin training an individual parent as a classroom aide. We have found that parent counseling conferences of this nature often do much to avert the "rival parent" syndrome which is often experienced by both parent and teacher.

III. RATIONALE

Since a major goal of our work with learning disabled children aims at helping parents to modify those familial factors which perpetuate the child's disturbance, our experiences relative

to expanding and enhancing the three main methods of parental involvement in the JAS treatment programs has led us to a philosophy in which the central theme is an all-out, concentrated effort toward making allies of

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parents. Helping a parent move from feeling helpless and dependent upon the professional staff, to a position of strength in relationship to his own, as well as to other children, is most meaningful. Growing out of this central theme, there are several basic assumptions:

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1. The best "therapists" a child can have are his mother and father.
2. Many parents unwittingly perpetuate the unacceptable behavior of their children due to either a lack of knowledge, a feeling of helplessness, or psychological conflicts.
3. The troubled child should not be isolated from, and treated outside of his family environment.
4. The trained professional has an obligation to share his knowledge and skills with parents, thus becoming the facilitator through whom many children can

avoid long-term specialized school and treatment settings.

5. Even in cases of the most severely disturbed parents and marriages, the child with delayed psycho-educational development cannot wait for such problems to be solved; nor does he have to wait. Many parents who fall within this category can be quite successful in helping their own and other children to achieve more acceptable and age-appropriate behavior.

Slide #28 IV. THE JULIA ANN SINGER PARENT ASSOCIATION

Although a child's average length of stay at JAS is only 3 or 4 months, we have been impressed by the number of parents who remain with us as "alumni parents," long after their children leave the agency. Many of these parents have joined with the parents of children currently in treatment and have formed The Julia Ann Singer Parent Association (JASPA). Now in its second year, the group at first was guided by an educational therapist who is the Coordinator of Parent Involvement for the JAS programs. A person of much empathy for parents of disturbed children and possessing great skill

in relating to these parents, this teacher successfully led the group to its present autonomous state of functioning. They have elected their own slate of officers and they have complete say over their activities.

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Upwards of 40 members in this group meet at the Center one evening a month for about 2 1/2 hours. They plan their own programs and agenda, invite speakers, and often arrange for purely social functions. Brought together by a common bond and bolstered by the knowledge that the growth and progress that they have seen in their own children has been largely due to their own efforts, they are eager to help others. They have never failed to respond to a request for help from the staff, and they have made invaluable suggestions for the improvement of the services and programs. They keep a file of clippings and resource material concerning the handicapped child, and they recently began to publish a quarterly newsletter.

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V. STEPS TOWARD A STAFF-PARTNER ROLE

The question of when and at what level to involve parents in consideration of a staff-partner role must be considered very carefully and on an individual basis. When parents come

to JAS they need help and are hurting. One of the primary goals of the staff is to assess each individual parent's strengths, capacities and willingness to leave the position of a hurting, dependent parent and cross over to the role of a staff-partner where he or she can begin to see themselves not primarily as "guilty" receivers of service, but as agents of service to others and givers to the program on all levels. True, some parents are initially too frightened to undertake direct heavy responsibility in our educational treatment programs. This fear, when it exists, is taken into consideration and respected by staff when making assignments.

A. The First Contact:

Appropriate ways for involving new parents have been explored in varying sequences by the Parent Association and the staff. At present, new parents are met by "welcoming alumni parents" within the first week of the new child's enrollment. The Parent Association makes every effort to match up new parents with "welcoming" parents on the basis of similarities of presenting problems. At this informal meeting the new parents are informed of the various

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activities available to them and are invited to join the Association at its next meeting. Incidentally, there are no dues payable to the Association; the ticket of admission is acceptance into one of the JAS programs. Also at this first welcoming meeting, any questions that new parents may have about the extent of involvement and the attitude of the JAS staff are answered. At no time are the alumni parents expected to report back to the staff on their meeting with the new parents.

Soon after this initial contact, the "old" parents make a telephone call to the "new" parents and arrange to meet with them again to further discuss membership in JASPA, and the varying roles available to them as staff-partners. An active attempt is made at this meeting to gain some commitment on the part of the new parents. Whenever possible, staff and JASPA members work together to determine the type and timing of various assignments.

B. Orientation:

In addition to the "welcoming parent" meetings, which are in themselves a method of orientation, the agency has been experimenting with other ways of exposing new parents to the

over-all view of the agency's programs, philosophy underpinning the short-term approach, and our expectations for staff-partner participation.

One way of approaching these goals is for the medical director to give a presentation to new parents in a group. This presentation can be videotaped and used later by senior staff members at similar meetings. Another method is to have the senior staff member who is the Coordinator of Parent Involvement hold periodic group meetings for new parents, using the same content, or perhaps the actual tape of the director's presentation. Alumni parents are also invited to these meetings to perform the same functions as they would as "welcoming" parents. In addition, staff and parents can explore together the new parents' interests in the various opportunities of parent-staff partnership, and alumni parents can discuss the activities of and answer questions about JASPA.

Due to the numbers of parents who come to the agency on an open-ended basis because of the short-term approach, the advantages of the group method of orientation are obvious.

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or
Proj. #4

C. Staff-Partner Capacity Rating:

When a child is accepted for treatment at JAS, a strong effort is made by the staff, with the cooperation of JASPA, to explore and rate the parents' potential for staff-partner capacity systematically and to find meaningful participation in the program for each parent, regardless of his or her psychopathology.

In the 3-to-6 month life of the case, a systematic, formal review is held at least twice in all instances, and very often three times. At the initial staff review, parent participation is thoroughly discussed from two main aspects: (1) in relation to the child; and, (2) in relation to the program. At this time, the staff rates each parent's staff-partner capacity on a scale of from one to six; "1" indicates that the parent is seen as very dependent and mainly able to receive service, "6" indicates that the parent has demonstrated a high ability to be active in the program, even at the level of policy making. Assignments for the parent to increase his or her staff-partner capacity are made when possible and noted on the pertinent portion of the case flow sheet. (See Appendix A.)

Subsequent assignments are also recorded, and around the time of termination staff-partner capacity of each parent is again rated.

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In addition, the staff member who is the Coordinator of Parent Involvement keeps a running record of all Parent Participation activities (See Appendix B.), enabling us to know, at any given time, the quantity and quality of involvement of a particular parent. This record is also very helpful to us in refining, expanding, and enhancing our Parent Participation opportunities toward staff-partnership.

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Finally, each child and his family receive a follow-up evaluation five months after termination from JAS. At this interview, it is the responsibility of the interviewing staff member to evaluate each parent's staff-partner capacity and activities as of that time, and to enter this information on the Follow-Up Tracking Data Form (See Appendix C.).

VI. POSSIBILITIES FOR STAFF-PARTNERSHIP

The possibilities for parent staff-partnership are numerous. These may include, but are not limited to:

. Serving on the JAS Advisory Board

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. Helping with the dissemination of the programs to the larger community, both professional and geographic.

. Participating in fund-raising efforts.

. Becoming teachers of other parents whose children are having difficulties.

. Serving as the "transition bridge" for the child from our setting to his new one in the regular community.

. Representing the agency to the local television, radio, and news media.

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. Acting as a potent force in motivating city, county, and state educational systems to incorporate some of our techniques into the classroom.

. Participating in staff in-service training workshops.

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. Attending professional conferences and seminars and reporting back to full staff and other parents.

. Serving as "welcoming parents" for the parents of children newly accepted at the Center.

. Observing and recording children's behavioral growth.

. Working in the classroom as a teacher or a teacher's aide.

. Acting as interpreter to non-English speaking families.

Proj. #7

A typical progression (See Appendix D.) in the staff-partner role might occur as follows:

1. First week - (a) Meet with "welcoming parents."
   (b) Attend orientation for new parents.
2. Second week - Observe and record data regarding behavior and child-teacher interactions with own child.
3. Fourth and Fifth week - Observe and record data regarding other children in the classroom.
4. First month - Attend JASPA meeting.
5. Sixth week - Participate with staff in "In-Staff Training Workshops."
6. Seventh week - Attend professional conference or seminar and report back to staff and other parents.
7. Eighth week - Begin to participate in Home Visit program, Family Demonstration therapy,

Perceptual-Motor Retraining Sessions, or Speech and Language Sessions as co-therapist.

8. Tenth week - Begin to work in the classroom as teacher's aide.
9. Fifteenth week - Act as "welcoming parent" to new parents to the Center.
10. Eighteenth week - Serve as "transition bridge" for a child leaving JAS, during his first 3 weeks in a regular community setting.

Naturally, the timing of these assignments will be governed by many variables, and not all parents have the time, inclination, or the capacity to become involved this intensely.

It is of interest to note that all of the above activities in the way of assuming the role of staff-partner go right along side of, and at the same time as, the direct treatment services that parents receive in relation to their particular child. It may seem to some, to be a lot to ask of a parent of a disturbed child, but we are continually impressed by the

number of parents who seem to welcome this kind of involvement, and who remain with us as "alumni parents" and active members of JASPA long after their children terminate treatment. Some examples:

. Mrs. A., the mother of a 5 1/2 year old child who came to us last year with severe behavior problems aggravated by an underlying neurological deficit. This child has now functioned in a normal nursery school for the past year. Mrs. A. continues to be involved at the Center. She makes evaluative visits to regular community nursery schools, and has become proficient enough to carry out Perceptual-Motor Pretraining Sessions with children both at the Center and in Public School settings.

. Mr. B., the father of a child who entered JAS severely lacking in any sense of his own identity or value. The child now functions in the public school system. Both Mr. and Mrs. B. continue their involvement with the Center. Mrs. B. helps with the Parent Orientation sessions, and Mr. B. is one of the officers of JASPA and also in charge of the welcoming parent program.

. Mrs. C. is the mother of a child currently attending our therapeutic nursery school for problems of controlling behavior with autistic features. Mrs. C. is in the classroom as a teacher's aide, as well as volunteering to do clerical services for JASPA. Bi-lingual, she has involved herself in working with non-English speaking parents new to the agency; she indicates that she would like to stay on to help at JAS even after her child leaves for a normal community setting.

Slide #39 VII. THE SOMETIMES ROCKY ROAD TOWARD STAFF-PARTNERSHIP

It has been our experience that intensive and meaningful parent participation on the staff-partner level is not easily accomplished, particularly in the beginning. And although not every eventuality can be planned for, there are, we believe, a few expectations that can be counted on in the development of a program such as the one described here.

In many agencies such as JAS, the professional staff is largely trained in analytic or anaclytic long-term psycho-therapeutic

Slide #40 approaches with children. In some of these more traditional settings there has been an ar-

unfortunate tendency on the part of some highly skilled professionals to view parents of disturbed children as the ones "who made their kids sick," and, at the same time, to view the children as "victims" who must be saved from the "bad guys." True, in such agencies parents are usually given social work therapy; but it has been suggested that this just underlines their sense of failure and incompetence, particularly as they observe their children separately interacting more wholesomely with the "professional" parental substitute. Very little seems to be done in an active, demonstration way to foster the strength of the parents. Unfortunately, this condemnation of parents from whom children must be rescued often can operate on an unconscious level in some professionals, in spite of a wholesome conscious attitude toward meaningful parent participation. This seems to be particularly true when a psychologically disturbed parent enters the program. Staff often attempt to block his potential to function on any level of staff-partnership and thereby reinforce his dependent, receiving-help-only position. Since

most of us who work with young chiddren have a very strong maternal and protective instinct toward the children, it is sometimes difficult for us to "give up" the child, particularly after what appears to be a too brief treatment span. It also makes it difficult for us to fully accept the parent as the primary agent of change in a child's life. Our maternal feelings can make us overpossessive of the child we treat. Along with this feeling there is often a strong conflict within us. Part of us senses that the child is indeed ready to proceed to the next level of his development, out in the regular community setting. Another part of us wants desperately to be able to enjoy the child's enjoyment of his new-found growth and capabilities. It is a knot that is often Gordian and implies the need for some very skillful in-staff training.

Another roadblock to meaningful parent staff-partnership may often be found within the parents themselves. We have found that many parents at first do not believe that we are serious about helping them to become staff-partners. They usually translate this into a belief that we want them to be janitors, file

clerks, office boys, or second-rate teacher's aides. Their own identity as parents has often been so crushed by the community's stigmatization of their disturbed child that they find it almost impossible to believe that there is a group of "professional" people ready to accept them as allies, without accusing them of anything, at least on a conscious level. Too, when they come to us so hurting and so needy, with a child whom they view as a nursery school "dropout"--often from several schools--it is not easy for them to see themselves in any type of leadership role. They feel the need to wait until that time when the pain begins to subside, and they can see some development and growth in their child. Our own theoretical conviction, however, is that the identity of the parent as a functioning, useful adult human being can help to alleviate some of the frustration around their child's developmental lags, and thereby foster a healthier, more optimistic parent-child interaction.

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Finally, there is the community problem of resistance to the integration of disturbed children into normal classrooms. Solution

here requires great skill on the part of all staff in public relations, consultation techniques, and liaison efforts--such as advocacy--to educate public officials and community group leaders to the value of this approach, not only in terms of the child's continuing health, but also in terms of savings in the manpower-dollar.

Slide #42 VIII. IMPLICATIONS FOR IN-SERVICE STAFF TRAINING

Recognizing that each agency which attempts to help handicapped children and their families is different and in some aspects unique, it is not the intent of this paper to offer a formula for full parent participation, which, if followed, will assure its users success. Nevertheless, from the experience in this area to date at JAS, there are, I feel, some valid suggestions which can be made, and which may prove helpful to others.

It should come as no great surprise to anyone that the "set" of any agency--through its policies, its leadership and its staff--will greatly determine the degree of success achieved by any one of its programs. We are convinced, therefore, that the importance of in-service staff training demands top priority in the institution of any new program.

Professional staff needs, and indeed expects, some orientation and education preliminary to venturing into new and perhaps unfamiliar territory. In-service staff training is required on three fronts: staff attitudes, staff knowledge, and staff skills--and in that order.

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or
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Some staff trainers may be shocked and inclined to dispute, while others will agree that staff attitudes is perhaps the most difficult area of training. However, unless the potential program initiators have a belief and conviction that amounts to zeal for what they are going to do, then the ultimate results will fall miserably short of the goals. Open and free "no-holds-barred" discussions should be the rule rather than the exception. Freedom and opportunity for staff to express their individual and/or collective opinions needs to be provided every step of the way, without fear of reprisal. Administrators or those responsible for staff training must often have exceptional resources of patience, wisdom and understanding. They must also be aware that because attitudes operate on two levels--conscious and unconscious--they may run into

situations wherein it seems to them that although staff "flesh" is willing, staff "spirit" is weak. Dealing with this contingency obviously calls for a great deal of training skill. For example, in my travels around the country it seems to me that one of the most common problems encountered in agencies treating young children is a reluctance to have parents in the classroom, particularly with their own child. The implication most often seems to be one of fear of contamination. However, most staff will readily admit that since the children are with the parents much more of the time than they are in the agency setting, it is imperative to help the parents obtain similar knowledge and skills. Often, then, the problem for trainers is not the question of whether or not the parents should be involved, but HOW to involve them.

Staff training in the area of new or additional knowledge regarding parent involvement can be accomplished in a variety of ways. On-site visits by qualified consultants, exploration and discussion of the body of literature, conferences, seminars, and formalized courses

are a few which come immediately to mind. My personal bias and experience has led me to the belief that probably the most impressive method for accomplishing in-staff training is to provide as many opportunities as possible for staff to make on-site visits to other agencies which have similar programs in operation. And, where finances permit it, I would put this at the top of my list.

Obtaining skills, it seems to me, is the last step in the process, and is predicated on the achievement of the first two. Practical application of positive attitudes and knowledge will lead to the attainment of skill. While imitation may only lead to attainment of good technique, it can also be an acceptable starting point which leads to modification, adaptation, and refinement of skills. Periodic, if not continual, objective reassessment and open discussion can then turn what was merely skill into a very lively ART.

IX. CONCLUSION

Parent participation as staff-partners at JAS is one way in which our staff has come to see itself not as "therapists" who as individuals

"cure" children, but as catalysts who, in as brief a period of time as possible, introduce something new into the child's life. We try to understand the child's needs so that we can better give his parents those techniques and tools to provide what he will need for a long time. Most important, we try to help both

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the child's parents and teachers assume the primary educational and therapeutic roles within his natural home and community. We are convinced that parent staff-partnership is the best route, albeit sometimes arduous, to the prevention of long-term isolation and segregation of emotionally disturbed children from the world which we feel can help them the most--the world of their parents, teachers and peers.

X. APPENDICES

PROBLEM PROGN.

PARENT PARTICIPATION

RELATION TO CHILD

1. ASSESSMENT (Fam. patterns which perpetuate child's problems)
(a)
(b)
(c)

2. Fam. Inter. Scales - Major Deficits
(a)
(b)
(c)

BEHAVIORAL OBJECTIVES
1.
2.
3.

RELATED TREATMENT MODALITY
1.
2.
3.

Changes & Rationale

TERMINATION EVALUATION
1. Family Patterns (Changes in)
(a)
(b)
(c)

2. Family Interaction Scales
(a)
(b)
(c)

3. Behavioral Objectives
Family:

Mo:

Fa:

RELATION TO PROGRAM

Staff-Partner Capacity:
Rate - 1 - Low, very dependent/mainly able to receive service,
6 - High, active in program/policy making.

Mo. 1 2 3 4 5 6 Fa. 1 2 3 4 5 6

ASSIGNMENTS (Objective is to increase staff-partner capacity)

Mo. 1 (Date_____) -

2. (Date_____) -

Fa. 1. (Date_____) -

2. (Date_____) -

TERMINATION EVALUATION

Staff-Partner Capacity:

Mo. 1 2 3 4 5 6 Fa. 1 2 3 4 5 6

Comments: Mo. -

Fa. -

New Behavioral Objectives at Termination
Family -

Mo. -

Fa. -

Staff Recorder_____

OVERALL OBJECTIVES

PARENT PARTICIPATION - GENERAL

1. Increase parents' Staff-Partner* Capacities
2. Develop parents' effectiveness in Dissemination (including future funding)
3. Develop Parent Alumni Corps to help with all phases of Program Implementation

STAFF - PARTNER In classroom Help new parents Help new trainees Dissemination - Fund raising Program planning SPECIFIC OBJECTIVE (S) -for each activity:		ACTIVITY (include who present from staff, present parents, Alumni parents and others) LIST	IMPRESSION OF IMPACT ON PARENTS, STAFF and COMMUNITY (include ideas for change or next steps in parent participation) Also RATE--General impression of Overall Parents' Staff - Participation at beginning and end of activity. 1 → 6 1=dependent - mainly seek help 6=Policy making - Program Planning RATE: Beg → End	HOURS
2/26	February assignments	Classroom participation: Castro - 6 hrs. Watanabe - 12 hrs.	Mrs. Castro's self image much more positive as she began to see herself as effective staff-partner.	1 ↓ 3
2/3 ↓ 3/3	Parent Committee members to make plans for next meeting. Jo Ann be responsible for program notes, etc.	J. Tachibana, M. Watanabe accepted and carried through on assignments. J. Vanover mailed notices to interested parents.	These parents very capable in assignments & fulfilled roles of staff-partner. Staff need only act as advisor to group in future.	5 ↓ 6
3/3	JoAnn hear speaker from CANHC and to hear from committee headed by F. Bruck on Industry Financing.	Present parents: Carelli (2); Bruck; Welch; Potter (2); Watanabe. Alumni: Deane; Jacob (2); Spencer (2); Estte; Cohen; Tachibana (2); Robinson (2); Enochs; Vanover; Breen (2). JAS Board: Lichtenfeld; Pink; Schwarz; Moss; Seltzer. Friends: Hollen; McGinness. Staff: Williams; Jones; Scrivner	Meetings conducted by parents - very little intrusion by staff	5 ↓ 6 — 2½

APPENDIX B

FOLLOW-UP TRACKING DATA

FOLLOW-UP DATE_____ CHILD'S NAME_____ AGE THEN_____

RATER_____ TERMINATION DATE_____ AGE NOW_____

Psycho-Ed. Assessments (CHILD)	Related to Child	Related to Program	Assessment of Maintenance in Reg. Community
1. TESTS (a)	1. Fam. Perpetuating Factors:	Present Staff-Partner Capacity	1. School
(b)	(a)	If Mo. not involved, check___	
(c)	(b)	If Fa. not involved, check___	
(d) Ed. Assess. (Deficits)	(c)	Explain:	(a) Role Duration (if any) of Trainee Match in school Transition:
2. Language -	11. Fam. Inter. Scales	Mo.	
3. Self-Con. -	(a)	Fa.	
4. W/Parents -	(b)	Staff-Partner Rating	
5. To Peers -		Mo. 1 2 3 4 5 6	
6. W/Other Adults -	(c)	Fa. 1 2 3 4 5 6	11. Other Commun. Resources:
7. Resp. Act. -	F. U. Eval. of Orig. Behav. Obj.: Parents:	Assign. since term.	1.
8. Self-Help -		Mo. - Date_____	
9. Affect -	1.	Date_____	2.
10. Neuro/Med. -			
RCNS -	2.	Fa. - Date_____	111. Trainee Match Follow-Up:
SCALES DX -	3.	Date_____	1.
KOHN -		F.U. Status of add'l Term. Behav. Obj.	2.
F. U. Eval. of orignial Behavioral Objectives		Family:	
Child:			
1.		Mother:	
2.		Father:	
3.			

APPENDIX C

A TYPICAL PROGRESSION IN THE STAFF-PARTNER ROLE

WEEK	ACTIVITY
1. FIRST WEEK	(a) MEET WITH "WELCOMING PARENTS." (b) ATTEND ORIENTATION FOR NEW PARENTS.
2. SECOND WEEK	OBSERVE AND RECORD DATA REGARDING BEHAVIOR AND CHILD-TEACHER INTERACTIONS WITH OWN CHILD.
3. FOURTH AND FIFTH WEEK	OBSERVE AND RECORD DATA REGARDING OTHER CHILDREN IN THE CLASSROOM.
4. FIRST MONTH	ATTEND JASPA MEETING.
5. SIXTH WEEK	PARTICIPATE IN STAFF IN-SERVICE TRAINING WORKSHOPS.
6. SEVENTH WEEK	ATTEND PROFESSIONAL CONFERENCE OR SEMINAR AND REPORT BACK TO STAFF AND OTHER PARENTS.
7. EIGHTH WEEK	BEGIN TO PARTICIPATE IN HOME VISIT PROGRAM, FAMILY DEMONSTRATION THERAPY, PERCEPTUAL-MOTOR RETRAINING SESSIONS, OR SPEECH AND LANGUAGE SESSIONS AS CO-THERAPIST.
3. TENTH WEEK	BEGIN TO WORK IN THE CLASSROOM AS TEACHER'S AIDE.
). FIFTEENTH WEEK	ACT AS "WELCOMING PARENT" TO NEW PARENTS TO THE CENTER.
). EIGHTEENTH WEEK	SERVE AS "TRANSITION BRIDGE" FOR A CHILD LEAVING JAS, DURING HIS FIRST 3 WEEKS IN A REGULAR COMMUNITY SETTING.

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